



**CHRONIC RENAL DISEASE PROGRAM  
REQUEST FOR MEDICAL EXCEPTION Auryxia<sup>®</sup>**

**Please note: This form must be included with the medical exception request.**

|   |  |
|---|--|
| Patient's Name:   |  |
| CRDP ID Number:   |  |
| Name of Product for which Exception Requested:  | <b>Auryxia<sup>®</sup> (6 tabs/daily maximum)</b> - please submit date therapy was initiated, current CaPO4 lab values, and if ongoing therapy, please also include labs prior to initiating therapy.                  |
| Treatment Modality:   | <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Transplant   |
| <ul style="list-style-type: none"> <li>• Documented usage/clinical failure with Renvela 9 tabs per day required or Fosrenol 3000mg per day.</li> <li>• Must have proof of other insurance coverage, such as Medicare Part D or another insurer.</li> <li>• If the other insurance requires a prior authorization, it must be approved, prior to CRDP providing reimbursement for any claim.</li> <li>• CRDP must be secondary payor on any associated claim for this agent.</li> <li>• In the event of non-compliance, CRDP will not continue reimbursement.</li> </ul> |  |
| Prescribing Physician:  |  |
| Physician NPI Number:   |  |
| Telephone Number:   | (     ) -<br>Area Code   |
| Signature of Facility Dietitian:  | Please indicated that the patient has been educated about dietary restrictions to control phosphate levels: <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br><b>Signature:</b> _____ <b>Date:</b> _____ |
| Facility Name:  |  |
| Facility Address:   |  |
| Telephone Number:   | (     ) -<br>Area Code   |
|   | <input type="checkbox"/> Check box if you would like to receive a status update of request via email. If box checked, please provide email address and facility ID and NPI.  |
| Facility ID and NPI Number(s):  |  |
| Email Address:  |  |
| Physician Signature:  | Date:  |

If you have any questions, please do not hesitate to contact the Chronic Renal Disease Program Drug Utilization Review Unit at 1-800-835-4080 or **FAX this form and attachments to 1-888-656-5076.**

RETURN THIS FORM AND ATTACHMENTS TO:

Chronic Renal Disease Program  
Drug Utilization Review  
P.O. Box 8811  
Harrisburg, PA 17105-8811  
or **FAX to 1-888-656-5076**